

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09104

9117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>				c. LENGTH OF STAY in 1b <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Law</u> Last <u>Arnt</u>				4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20 1932</u>		9. AGE (In years last birthday) <u>25</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTH PLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Roy Arnt</u>				14. MOTHER'S MAIDEN NAME <u>Kennie Mary Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT <u>George R. Arnt, Jessup, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hodgkin's Disease</u> 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 8, 1957</u> to <u>Sept. 8, 1957</u> , that I last saw the deceased alive on <u>Sept. 8, 1957</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank E. Shipley</u>				ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>9/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>9/10/57</u>		<u>Mt. Olivet Cem.</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Donaldson</u>				ADDRESS <u>Lanham</u>		24a. REC'D BY REGISTRAR <u>Not P 11 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Carol J. Shipley</u>	

9097 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Ala.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Ala.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		d. STREET ADDRESS <i>141 Conduit</i>	
3. NAME OF DECEASED (Type or print) <i>Peter C. Apollo</i>		4. DATE OF DEATH <i>9-21-1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 1899</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Funeral Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Christos Apollo</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Nicholas J Madris</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592X Azotemia</i> DUE TO (b) <i>Nephritis, Chronic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>6 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12-20</i> , 19 <i>56</i> to <i>9-21</i> , 1957, that I last saw the deceased alive on <i>9-21</i> , 1957, and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6 SHAW ST ANNAPOLIS, MD</i>			
ACTUAL SIGNATURE <i>James R. Martin</i>		DATE SIGNED <i>9/23/57</i>	
PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		<i>6 SHAW ST ANNAPOLIS, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-24-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St James Greek</i>	22d. LOCATION (City, town, or county) (State) <i>Pova Road Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>—</i> 24b. REGISTRAR'S SIGNATURE <i>—</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

U.S. DEPT. OF HEALTH

MAINE

MAINE STATE DEPARTMENT OF HEALTH - BATTLE CREEK, ME

BUREAU V. S.

SEP 25 1957

RECEIVED

9098

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH ANNAPOLIS, MARYLAND</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEW</u> Middle <u>MORTON</u> Last <u>ATKINS</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 Sep 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Morton ATKINS</u>		14. MOTHER'S MAIDEN NAME <u>Maria Theresa KENNEDY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WWI & WWII</u>	
17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EMBOLISM, PULMONARY</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One week</u> <u>8 Mos.</u> <u>3 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 September 19 57</u> , to <u>3 September 19 57</u> , that I last saw the deceased alive on <u>3 September 19 57</u> , and that death occurred at <u>4:00A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>CDR MC USN U.S.N. Hosp. Anna. Md.</u>	
PHYSICIAN'S NAME (Type) <u>F. W. MEYER JR</u>		DATE SIGNED <u>9-3-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 5-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 6 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 24

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1127 Old Annapolis Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest Floyd Baldwin</u>				4. DATE OF DEATH Month <u>September</u> Day <u>28th</u> Year <u>19 57</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/94</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rhea County, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Driver's License.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>9/28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov. 10-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR DATE <u>10/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	

RECEIVED

OCT 8 1957

BUREAU V. 2

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF DEATH: _____
5. PLACE OF DEATH: _____
6. CAUSE OF DEATH: _____
7. MANNER OF DEATH: _____
8. SIGNATURE OF EXAMINER: _____
9. SIGNATURE OF WITNESS: _____
10. SIGNATURE OF CORONER: _____

11. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

12. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

13. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

14. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

15. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

16. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

17. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

18. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

19. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

20. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9119 CERTIFICATE OF DEATH

09107

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A.C.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCHTON LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCHTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CYNTHIA</u> Middle <u>ANN</u> Last <u>BLUNT</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 2 1957</u>
9. AGE (In years last birthday) yrs. <u>3 weeks</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BLUNT, WILLIAM</u>		14. MOTHER'S MAIDEN NAME <u>ROSA LEE MACKELL BLUNT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>AAC HEALTH DEPT.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL HEART DISEASE</u> <u>754.4</u> DUE TO <u>PROBABLY VALVULAR DEFORMITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEE AAC HEALTH DEPT. RECORDS</u> DUE TO (c) <u>SEE AAC HEALTH DEPT. RECORDS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mon</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>BIRTH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>I didn't see body during 90 hrs</u> last saw the deceased alive on <u>Sept 26</u> , 19 <u>57</u> , and that death occurred at <u>about 3:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Churchoon, Md.</u> DATE SIGNED <u>FD Hendricks</u>			
ACTUAL SIGNATURE <u>FD Hendricks</u>		M.D. <u>Shady side</u>	
PHYSICIAN'S NAME (Type) <u>FD Hendricks</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Churchton</u>		22d. LOCATION (City, town, or county) (State) <u>Churchton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese & Anna, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>SEP 2 '57</u>			

CERTIFICATE OF DEATH

CHAS. ALVIN

BUREAU V. 3

OCT 3 1957

RECEIVED

CERTIFICATE OF DEATH

0910878

Reg. Dist. No.

9120

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, 19x1.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		d. STREET ADDRESS Box 266, Rt. 3	
3. NAME OF DECEASED (Type or print) First Alex Middle Bounds Last Bounds		4. DATE OF DEATH Month 9 Day 2 Year 19 57	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) yrs. 68?		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Records		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized and Cerebral Arteriosclerosis DUE TO (c) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to September 2, 19 57 , that I last saw the deceased alive on September 2, 19 57 , and that death occurred at 10:00p PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 9-3-57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE OF BURIAL, CREMATION, REMOVAL 9/3/57	22c. NAME OF CEMETERY OR CREMATORY St. John Wesley (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James		24. REC'D BY REGISTRAR 9/6/57 24b. REGISTRAR'S SIGNATURE K. M. Joyce	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		JAMES A. [illegible]	
DATE OF BIRTH		[illegible]	
PLACE OF BIRTH		[illegible]	
OCCUPATION		[illegible]	
DATE OF DEATH		[illegible]	
PLACE OF DEATH		[illegible]	
CAUSE OF DEATH		[illegible]	
MANNER OF DEATH		[illegible]	
SIGNATURE OF PHYSICIAN		[illegible]	
SIGNATURE OF REGISTRAR		[illegible]	
DATE OF REGISTRATION		[illegible]	
PLACE OF REGISTRATION		[illegible]	
OFFICIAL SEAL		[illegible]	

BUREAU V. 2

SEP 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09109 *24*

Reg. Dist. No.

9121

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna</i>		c. LENGTH OF STAY IN 1b <i>6/17/57</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Same</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Box 150 - New Cut Rd</i>				d. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) <i>Reuben Elsworth Bowen</i>				4. DATE OF DEATH Month <i>Sept.</i> Day <i>12</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>7/27/95</i>	9. AGE (In years last birthday) <i>62</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bar tender</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Co.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Edward Bowen</i>				14. MOTHER'S MAIDEN NAME <i>Anna Chenoweth</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>W. W. # 1 218-01-791024</i>		17. INFORMANT <i>Bowen (same)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>3-6 wks.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. MANNER OF REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>14 Sept 1957</i>		22c. NAME OF CEMETERY OR CREMATOR <i>SATERS CEM</i>		22d. LOCATION (City, town, or county) <i>BALTO CO Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rolf C. B. M. Wallace</i>				ADDRESS <i>Pratt & Sticker Sts</i>		24a. REC'D BY REGISTRAR <i>SEP 16 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. Adkins</i>			

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

AUG

BUREAU V. 3

SEP 16 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 27

9122

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>	
c. LENGTH OF STAY IN 1b <u>2 Months</u>		d. STREET ADDRESS <u>Dunrovin Trailer Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort George G. Meade, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>William</u> Last <u>Bryan</u>		4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 March 1953</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Fayette N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. USA</u>	
13. FATHER'S NAME <u>Charles L. Bryan</u>		14. MOTHER'S MAIDEN NAME <u>Erna Marie Dietrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father, Charles L. Bryan-Dunrovin Trailer</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest - respiratory failure</u> <u>493X</u> DUE TO <u>Fulminating pneumonia Right upper</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fulminating pneumonia RT upper</u> and middle lobes. (c) <u>+ middle lobes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 Sept</u> , 19 <u>57</u> , to <u>4 Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4 Sept</u> , 19 <u>57</u> , and that death occurred at <u>2230</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Capt. A. Fiascone</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>USAH, Fort George G. Meade, Md. 4 Sep 57</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD FIASCONE, Capt, MC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK INC. 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>5 Sep 57</u>	24b. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Capt. MSC</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09112

9099

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General				e. STREET ADDRESS South River Manor			
3. NAME OF DECEASED (Type or print) Crozia First Middle Last Bunn				4. DATE OF DEATH Sept. 6 Month Day Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ruffin Fuller				14. MOTHER'S MAIDEN NAME Marildia Hinton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Doyet Edward Bunn, Rt.1, Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Fall (b) DUE TO Hypertension (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epileptic since childhood.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient subject to frequent "black out" spells. regularly.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8 4 57 p. m. 9 5 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis, Anne Arundel, Md.		
21. I certify that I attended the deceased from Sept. 5, 1957 , to Sept. 6, 1957 , that I last saw the deceased alive on Sept. 5, 1957 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jesse L. Wilkins		ADDRESS (Street, city or town, state) 98 Cathedral St.		DATE SIGNED Sept. 6, 1957			
PHYSICIAN'S NAME (Type) JESSE L. WILKINS, M.D.		Annapolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 8, 57		22c. NAME OF CEMETERY OR CREMATORY Hales Chapel		22d. LOCATION (City, town, or county) (State) Zebulon Johnston County, N.C	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR SEP 9 1957		24b. REGISTRAR'S SIGNATURE Mr. J. Sherry	

RECEIVED

SEP 9 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9123

CERTIFICATE OF DEATH

09113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Underwood Road				d. STREET ADDRESS Underwood Rd.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F Last BURGESS				4. DATE OF DEATH Month Sept Day 24 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 2, 1876		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (own farm)		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank P. Burgess				14. MOTHER'S MAIDEN NAME Soffie Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Edward Aisquith-Daughter- Riva, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 4hrs 10 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 19 46 , to Sept 24 19 57 , that I last saw the deceased alive on Sept 23 19 57 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED September 24, 1957							
ACTUAL SIGNATURE Edward G. Skeritt M.D.				PHYSICIAN'S NAME (Type) Edward Skeritt MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 27, 57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Brooklyn, A.A. Co., Maryland				23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.			
24a. REC'D BY REGISTRAR SEP 27 1957				24b. REGISTRAR'S SIGNATURE L. M. Jones			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Maryland		65		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
1914		Baltimore, Md.		Heart Disease		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Burial		Place of Burial		Name of Burial Place		Name of Minister	
1914		Baltimore, Md.		St. John's Church		Rev. [Name]	
Name of Burial Place		Name of Minister		Name of Undertaker		Name of Embalmer	
St. John's Church		Rev. [Name]		[Name]		[Name]	
Name of Undertaker		Name of Embalmer		Name of Funeral Home		Name of Casket	
[Name]		[Name]		[Name]		[Name]	
Name of Casket		Name of Funeral Home		Name of Casket		Name of Casket	
[Name]		[Name]		[Name]		[Name]	
Name of Casket		Name of Funeral Home		Name of Casket		Name of Casket	
[Name]		[Name]		[Name]		[Name]	

BUREAU V. S.

SEP 24 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.B.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>	c. LENGTH OF STAY IN 1b <u>x2</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 201</u>		d. STREET ADDRESS <u>Same</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Reid Calhoun</u>		4. DATE OF DEATH Month Day Year <u>September 14th. 19 57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/18</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager of South Baltimore General Hosp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphia, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Reid Calhoun</u>		14. MOTHER'S MAIDEN NAME <u>Laura Barbara ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 11 World War</u>		16. SOCIAL SECURITY NO. <u>218-07-5074</u>	
17. INFORMANT <u>Mrs. Mary Ann Calhoun (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>stating the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED <u>9/14/57</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore City Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Conakson</u>		24a. REC'D BY REGISTRAR <u>SEP 19 1957</u>	
ADDRESS <u>Laural Md</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Paslip</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 19 1957

BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09113

9125

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>25 y.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 336, Route 2, Margate</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Kimball</u> Last <u>Chalker</u>				4. DATE OF DEATH Month <u>Septmebe</u> Day <u>30th.</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/26/75</u>		9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rockland, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Amasa Kimball</u>			
14. MOTHER'S MAIDEN NAME <u>Beatrice Boyce</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>No</u>				17. INFORMANT Address <u>Mrs. Victor W. Volrath (daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular diseases</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 y.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June</u> , 19 <u>47</u> , to <u>Sept. 30th.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/27/57</u> , and that death occurred at <u>11/20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>9/30/57</u>	
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Floral Pk. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Binghamton, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				24a. REC'D BY REGISTRAR DATE <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 22, 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 2, 1968		MEMPHIS, TENNESSEE		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE	
CONGRESSMAN		HIGH SCHOOL		MARRIED	
PREVIOUS ILLNESS		HISTORY OF DRUGS		HISTORY OF ALCOHOL	
NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]	

BUREAU Y. 8

OCT 3 1957

RECEIVED

9100

CERTIFICATE OF DEATH

09116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 440 Dewey Drive		d. STREET ADDRESS 440 Dewey Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROLAND Middle F Last CHAMBERS		4. DATE OF DEATH Month September Day 27 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 6, 1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roland F. Chambers		14. MOTHER'S MAIDEN NAME Ursie J. Norfolk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215 28 7381	
(If yes, give war or dates of service) WW II		17. INFORMANT Mrs. Virginia Chambers-Wife- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from J. an. 19 50 to Sept. 27 , 1957, that I last saw the deceased alive on 9/25/57 , 19 57 , and that death occurred at 4:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Amos Garrett Blvd., Annapolis, Md. DATE SIGNED 9/28/57			
ACTUAL SIGNATURE S. Borssuck		PHYSICIAN'S NAME (Type) S. Borssuck M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 29, 57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR SEP 30 1957	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Amos Garrett	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John J. Jones		1957	
Age		Sex	
65		Male	
Race		Marital Status	
White		Married	
Place of Birth		Cause of Death	
Baltimore, Md.		Heart Disease	
Occupation		Date of Burial	
Teacher		1957	
Place of Burial		Signature of Physician	
St. John's Cemetery		[Signature]	
Name of Undertaker		Date of Issuance	
John J. Jones		1957	
Address		Signature of Registrar	
1234 Main St.		[Signature]	
City		Date of Filing	
Baltimore		1957	
County		Signature of Coroner	
Baltimore		[Signature]	
State		Date of Death	
Maryland		1957	

RECEIVED
SEP 30 1957
BUREAU V. 1

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 aa Co Horse Annapolis</i>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>aa Co General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Arthur Cole</i>		4. DATE OF DEATH <i>9-19-57</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown About 22</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Edward B. Cole</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT <i>Record of aa Co Home</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>Cerebral hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>904.9</i> DUE TO <i>Generalized arteriosclerosis.</i> (b) <i>331X</i> DUE TO <i>Generalized arteriosclerosis.</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured Rt. Femur</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug. 1, 1957</i> to <i>Sept 18, 1957</i> , that I last saw the deceased alive on <i>Sept 18, 1957</i> , and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Maurice Klanans M.D.</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md</i>	
PHYSICIAN'S NAME (Type) <i>MAURICE F. KLANANS</i>		DATE SIGNED <i>9/20/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-21-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sins</i>		24a. REC'D BY REGISTRAR <i>9/23/57</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. Smith</i>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

RECEIVED
 SEP 25 1957
 BUREAU V. 2

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE [Faint text]		TIME [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09118

9126

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		d. STREET ADDRESS <u>McKinsey Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>May</u> Last <u>DAY</u>		4. DATE OF DEATH Month <u>9-</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bastville</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Husband - George Day</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitral Stenosis</u> (c) <u>Rheumatic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>9-29-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-28-57</u> , 19 <u>57</u> , and that death occurred at <u>9:45</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md.</u> DATE SIGNED <u>9-29-57</u>	
PHYSICIAN'S NAME (Type) <u>R. HAHN</u>		<u>Severna Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carpenters Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Severna Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beebe, Jr. - Anna, Md.</u>		24a. REC'D BY REGISTRAR <u>10/2/57</u> 24b. REGISTRAR'S SIGNATURE <u>L. J. Dealy</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

3158

Name of Deceased		Sex		Age		Date of Birth	
Race		Marital Status		Occupation		Usual Residence	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Place of Death		Physician's Signature		Physician's Title		Physician's Address	
Manner of Death		Certified by		Date of Certification		Signature of Registrar	
Signature of Registrar		Signature of Medical Officer		Signature of Health Officer		Signature of Coroner	

BUREAU V. S.

OCT 3 1957

RECEIVED

Handwritten notes and signatures at the bottom of the form, including a large signature across the bottom right.

9102

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER WILLIAM DORSEY</u>				4. DATE OF DEATH <u>September 3 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 17, 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			
13. FATHER'S NAME <u>David Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Easton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give way or dates of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>219-30-4077</u>			
17. INFORMANT <u>Milton Dorsey (son)</u>				Address <u>31-Carnel St Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis due to Intestinal Obstruction</u> 57a.5 DUE TO <u>from a Volvulus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to Peritonitis & abdominal visceral Adhesions</u> DUE TO (c) <u>due to Peritonitis & abdominal visceral Adhesions</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/3</u> , 19 <u>57</u> , to <u>9/3/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/3/57</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. K. [Signature]</u>				ADDRESS (Street, city or town, state) <u>115-61-47 ST. FRANCIS, Md.</u>			
DATE SIGNED <u>9/6/57</u>				M.D. <u>115-61-47 ST. FRANCIS, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel ME Lendrie, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Anna, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 9/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. No. 1-1-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF REGISTRAR

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF FUNERAL HOME

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

23. SIGNATURE OF DECEASED

24. SIGNATURE OF DECEASED

25. SIGNATURE OF DECEASED

BUREAU V. S.

SEP 11 1957

RECEIVED

William R. ...
Union Chapel ...
P-8-27

9103

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis 10 'MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>818 BOOCHER AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGE W. EVANS</u>		4. DATE OF DEATH <u>SEPT. 22 1957</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 2, 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOAT REPR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOAT REPR.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Evans</u>		14. MOTHER'S MARDEN NAME <u>Not Known</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Cora I. Evans</u>		Address <u># 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330x Subarachnoid Hemorrhage</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 27</u> , 19 <u>57</u> , to <u>Sept 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 21</u> , 19 <u>57</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		M.D. <u>9/23/57</u>		PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Laylat Sons</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>9/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>D. French</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled with the registrars and be detached for use as the burial-transit permit. Then please remove, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9127

CERTIFICATE OF DEATH

09121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover				c. LENGTH OF STAY IN 1b 29 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box #7 Ridge Road				d. STREET ADDRESS Box #7 Ridge Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CLARENCE Middle A. Last FISHER				4. DATE OF DEATH Month SEPTEMBER Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 10 Hours 57 Min.		IF UNDER 24 HRS. Months 6 Days 10 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Blandon, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Fisher				14. MOTHER'S MAIDEN NAME Sarah A. Meyers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-36-4138		17. INFORMANT Mrs. Edna L. Fisher		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO chr Myocarditis DUE TO Diabetes Mellitus DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 18, 1948 to Sept 10, 1957 , that I last saw the deceased alive on Sept 10, 1957 , and that death occurred at 8:22 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE B B Brumbaugh M.D.				ADDRESS (Street, city or town, state) 7600 Main St Baltimore, Md			
DATE SIGNED 9/11/57							
PHYSICIAN'S NAME (Type) B B Brumbaugh				ELDERIDGE 27 MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard P. Sengler ADDRESS Glen Burnie, Md.				24a. REC'D BY REGISTRAR SEP 15 1957		24b. REGISTRAR'S SIGNATURE Clara Ashpazz	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

57

BUREAU V. 2

SEP 16 1957

RECEIVED

9128

CERTIFICATE OF DEATH

091222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Children's Center Hospital Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md. c. LENGTH OF STAY IN 1b 15 months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1634 R Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vessie Middle Gill Last Gill		4. DATE OF DEATH Month September Day 30 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1955
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME Hazel Gill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -	
16. SOCIAL SECURITY NO. -		17. INFORMANT Children's Center Address Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital osteogenesis imperfecta			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -		20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) -		(County) (State)	
21. I certify that I attended the deceased from 6/21/56 , 19 56 , to 9/30/57 , 19 57 , that I last saw the deceased alive on 9/30/57 , 19 57 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.		ADDRESS (Street, city or town, state) Children's Center, Laurel, Md.	
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.		DATE SIGNED 10/1/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 10/3-57	
22c. NAME OF CEMETERY OR CREMATORY Children's Center		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wilfred R. Ehrmantraut		24a. REC'D BY REGISTRAR DATE Oct 1-57	
24b. REGISTRAR'S SIGNATURE Thelma H. Hoadley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

RECEIVED
OCT 4 1957
BUREAU V. S.

Name of Deceased		Date of Death	
Age		Sex	
Race		Marital Status	
Place of Birth		Usual Residence	
Cause of Death		Manner of Death	
Physician's Signature		Registrar's Signature	
Date of Report		Place of Report	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG220 9-23-57 et

9129

CERTIFICATE OF DEATH

09123

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		LENGTH OF STAY (in this place) <u>X0</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 EDGEWALK RD.</u>				STREET ADDRESS (If rural give location) <u>118 EDGEWALK RD.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Elizabeth</u> (Middle) <u>A.</u> (Last) <u>Happel</u>				(Month) <u>9</u> (Day) <u>14</u> (Year) <u>57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>9-11-66</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bein</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Family - Same</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>coronary occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertensive cardio vascular disease</u>						14 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>43</u> , to <u>Sept 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>57</u> , and that death occurred at <u>6 p</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Keister</u>		M.D. <u>302 Paterson Ave Balto 25 Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>9/16/57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		DATE THEREOF <u>9-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		LOCATION (City, town, or county) (State) <u>BALTO.</u>	
24. REC'D BY REGISTRAR <u>SEP 17 1957</u>		REGISTRAR'S SIGNATURE <u>Eda Minton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McClurey Thomas</u>		ADDRESS <u>Edna</u>	

CERTIFICATE OF DEATH

1. FULL RESIDENCE (Street or Place)

2. SEX

3. AGE

4. DATE

5. OCCUPATION (If deceased was engaged in any occupation)

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED (If deceased was able to sign)

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF MINISTER OF THE GOSPEL

12. SIGNATURE OF CORONER

13. SIGNATURE OF WITNESSES (If deceased was unable to sign)

14. SIGNATURE OF DECEASED (If deceased was able to sign)

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF MINISTER OF THE GOSPEL

17. SIGNATURE OF CORONER

18. SIGNATURE OF WITNESSES (If deceased was unable to sign)

19. SIGNATURE OF DECEASED (If deceased was able to sign)

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF MINISTER OF THE GOSPEL

22. SIGNATURE OF CORONER

23. SIGNATURE OF WITNESSES (If deceased was unable to sign)

24. SIGNATURE OF DECEASED (If deceased was able to sign)

25. SIGNATURE OF PHYSICIAN

26. SIGNATURE OF MINISTER OF THE GOSPEL

27. SIGNATURE OF CORONER

28. SIGNATURE OF WITNESSES (If deceased was unable to sign)

29. SIGNATURE OF DECEASED (If deceased was able to sign)

30. SIGNATURE OF PHYSICIAN

31. SIGNATURE OF MINISTER OF THE GOSPEL

32. SIGNATURE OF CORONER

33. SIGNATURE OF WITNESSES (If deceased was unable to sign)

34. SIGNATURE OF DECEASED (If deceased was able to sign)

35. SIGNATURE OF PHYSICIAN

36. SIGNATURE OF MINISTER OF THE GOSPEL

37. SIGNATURE OF CORONER

38. SIGNATURE OF WITNESSES (If deceased was unable to sign)

39. SIGNATURE OF DECEASED (If deceased was able to sign)

40. SIGNATURE OF PHYSICIAN

41. SIGNATURE OF MINISTER OF THE GOSPEL

42. SIGNATURE OF CORONER

43. SIGNATURE OF WITNESSES (If deceased was unable to sign)

44. SIGNATURE OF DECEASED (If deceased was able to sign)

45. SIGNATURE OF PHYSICIAN

46. SIGNATURE OF MINISTER OF THE GOSPEL

47. SIGNATURE OF CORONER

48. SIGNATURE OF WITNESSES (If deceased was unable to sign)

49. SIGNATURE OF DECEASED (If deceased was able to sign)

50. SIGNATURE OF PHYSICIAN

51. SIGNATURE OF MINISTER OF THE GOSPEL

52. SIGNATURE OF CORONER

53. SIGNATURE OF WITNESSES (If deceased was unable to sign)

54. SIGNATURE OF DECEASED (If deceased was able to sign)

55. SIGNATURE OF PHYSICIAN

56. SIGNATURE OF MINISTER OF THE GOSPEL

57. SIGNATURE OF CORONER

58. SIGNATURE OF WITNESSES (If deceased was unable to sign)

59. SIGNATURE OF DECEASED (If deceased was able to sign)

60. SIGNATURE OF PHYSICIAN

61. SIGNATURE OF MINISTER OF THE GOSPEL

62. SIGNATURE OF CORONER

63. SIGNATURE OF WITNESSES (If deceased was unable to sign)

64. SIGNATURE OF DECEASED (If deceased was able to sign)

65. SIGNATURE OF PHYSICIAN

66. SIGNATURE OF MINISTER OF THE GOSPEL

67. SIGNATURE OF CORONER

68. SIGNATURE OF WITNESSES (If deceased was unable to sign)

69. SIGNATURE OF DECEASED (If deceased was able to sign)

70. SIGNATURE OF PHYSICIAN

71. SIGNATURE OF MINISTER OF THE GOSPEL

72. SIGNATURE OF CORONER

73. SIGNATURE OF WITNESSES (If deceased was unable to sign)

74. SIGNATURE OF DECEASED (If deceased was able to sign)

75. SIGNATURE OF PHYSICIAN

76. SIGNATURE OF MINISTER OF THE GOSPEL

77. SIGNATURE OF CORONER

78. SIGNATURE OF WITNESSES (If deceased was unable to sign)

79. SIGNATURE OF DECEASED (If deceased was able to sign)

80. SIGNATURE OF PHYSICIAN

81. SIGNATURE OF MINISTER OF THE GOSPEL

82. SIGNATURE OF CORONER

83. SIGNATURE OF WITNESSES (If deceased was unable to sign)

84. SIGNATURE OF DECEASED (If deceased was able to sign)

85. SIGNATURE OF PHYSICIAN

86. SIGNATURE OF MINISTER OF THE GOSPEL

87. SIGNATURE OF CORONER

88. SIGNATURE OF WITNESSES (If deceased was unable to sign)

89. SIGNATURE OF DECEASED (If deceased was able to sign)

90. SIGNATURE OF PHYSICIAN

91. SIGNATURE OF MINISTER OF THE GOSPEL

92. SIGNATURE OF CORONER

93. SIGNATURE OF WITNESSES (If deceased was unable to sign)

94. SIGNATURE OF DECEASED (If deceased was able to sign)

95. SIGNATURE OF PHYSICIAN

96. SIGNATURE OF MINISTER OF THE GOSPEL

97. SIGNATURE OF CORONER

98. SIGNATURE OF WITNESSES (If deceased was unable to sign)

99. SIGNATURE OF DECEASED (If deceased was able to sign)

100. SIGNATURE OF PHYSICIAN

101. SIGNATURE OF MINISTER OF THE GOSPEL

102. SIGNATURE OF CORONER

103. SIGNATURE OF WITNESSES (If deceased was unable to sign)

104. SIGNATURE OF DECEASED (If deceased was able to sign)

105. SIGNATURE OF PHYSICIAN

106. SIGNATURE OF MINISTER OF THE GOSPEL

107. SIGNATURE OF CORONER

108. SIGNATURE OF WITNESSES (If deceased was unable to sign)

109. SIGNATURE OF DECEASED (If deceased was able to sign)

110. SIGNATURE OF PHYSICIAN

111. SIGNATURE OF MINISTER OF THE GOSPEL

112. SIGNATURE OF CORONER

113. SIGNATURE OF WITNESSES (If deceased was unable to sign)

114. SIGNATURE OF DECEASED (If deceased was able to sign)

115. SIGNATURE OF PHYSICIAN

116. SIGNATURE OF MINISTER OF THE GOSPEL

117. SIGNATURE OF CORONER

118. SIGNATURE OF WITNESSES (If deceased was unable to sign)

119. SIGNATURE OF DECEASED (If deceased was able to sign)

120. SIGNATURE OF PHYSICIAN

BUREAU V. 3

SEP 17 1957

RECEIVED

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9:30

CERTIFICATE OF DEATH

09124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Borston Last Harrison		4. DATE OF DEATH Month Sept. Day 24th Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Frank A Harrison		14. MOTHER'S MAIDEN NAME Emma J Borston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 578-48-8925	
17. INFORMANT Florence V. Harrison		Address Hind Drive Shady Side Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Cardiovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Several years (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-24 , 19 57 to 9-24 , 19 57 , that I last saw the deceased alive on 9-24 , 19 57 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry N. Jones		ADDRESS (Street, city or town, state) Deale Md	
PHYSICIAN'S NAME (Type) Harry N. Jones		DATE SIGNED 9-24-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/57	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cem	22d. LOCATION (City, town, or county) (State) Coomer Manor Pk Co Md
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co - Riverdale Md		24a. REC'D BY REGISTRAR DATE 9-24-57	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V. 2

SEP 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09125

9104

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>HILLARY</u> Last <u>HILLARY</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Hillary</u>		14. MOTHER'S MAIDEN NAME <u>Mary Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Henry Hillary - Anna, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accidents</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>39 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>July 8</u> , 19 <u>52</u> , to <u>Sept 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>57</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D. <u>45 Franklin St. Annapolis, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-2-57</u>	
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	22d. LOCATION (City, town, or county) (State) <u>Davidsonville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beebe - Anna, Md.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u> DATE <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

OCT 8 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9131

Item 9 FilmG220 9-16-57 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tydings-On-Bay	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Paradise Ave. 03-522	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		d. STREET ADDRESS Cape St. Claire	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) BERNON L. HOUCK		4. DATE OF DEATH Month September Day 8 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1891
9. AGE (In years last birthday) 67 68		IF UNDER 1 YEAR Months 6 Days 6	IF UNDER 24 HRS. Hours 6 Min. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Oil	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME Martin William Houck	
14. MOTHER'S MAIDEN NAME Louise Pauline Felger		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.1	
16. SOCIAL SECURITY NO. 212-07-5651		17. INFORMANT J. Lloyd Wilkinson-4622 Wilmslow Rd. # 10	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 929.8 Myocardial Infarct Conditions, if any, which gave rise to immediate cause (b) Drowning (a), stating the underlying cause last. (c) Drowning			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9/7/ 19 57 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) water	20f. (City or town) (County) (State) Tydings on Bay Anne Arundel Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 9/9/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-11-57	22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR SEP 11 1957	
24b. REGISTRAR'S SIGNATURE Mr. J. French		24c. ADDRESS Ellsworth Armacost -4600 Liberty Hghts. Ave.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 11 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09127 28

9132

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1mo. 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
f. STREET ADDRESS 403 Aisquith Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Doram Last Johnson				4. DATE OF DEATH Month 9-7- Day 19 Year 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 83? yrs.		IF UNDER 1 YEAR Months + Days + Hours + Min. +		IF UNDER 24 HRS. Months + Days + Hours + Min. +			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Peter Doram				14. MOTHER'S MAIDEN NAME Sarah Francis Doram			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -				16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Hospital Records Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) - - - - -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Age, Arteriosclerosis (General)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-20- , 19 57 , to 9-7- , 19 57 , that I last saw the deceased alive on 9-7- , 19 57 , and that death occurred at 10:05 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 9-9-57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF sep 14		22c. NAME OF CEMETERY OR CREMATORY St. Calvary		22d. LOCATION (City, town, or county) (State) St. Anne's, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Baker ADDRESS 918 Broad Hill Ave				24a. REC'D BY REGISTRAR SEP 10		24b. REGISTRAR'S SIGNATURE A. M. Joyce	

2010

SEP 16 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09128

CERTIFICATE OF DEATH

9133

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Jessup</u>		LENGTH OF STAY (In this place) <u>14 yrs.</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Jessup</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montevideo Road</u>				STREET ADDRESS (If rural give location) <u>Montevideo Road</u>			
3. NAME OF DECEASED (Type or Print) <u>MAGGIE L. LANCASTER</u>				4. DATE OF DEATH <u>September 3, 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Nov. 11, 1880</u>	
9. AGE last birthday <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Jessup, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Henry Marks</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Bennett</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT & ADDRESS <u>Miss Bertha L. Lancaster Same as 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						19. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
151X IMMEDIATE CAUSE (A) <u>Cancer stomach</u>						1. yr +	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Renal carcinoma of the</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial infarct 2 mo</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Oct 36, 1936</u> , to <u>Sept 3, 1957</u> , that I last saw the deceased alive on <u>Sept 3, 1957</u> , and that death occurred at <u>10:23</u> M., from the causes and on the date stated above. <u>9/5/57</u>							
SIGNATURE <u>Richard Y. Singleton</u>				ADDRESS (Street, city, town, state) <u>M.D. 3609 Main St. Edmonds 27 Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 7/57</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		LOCATION (City, town, or county) (State) <u>Wash. Blvd., Md.</u>	
24. REC'D BY REGISTRAR <u>SEP 9 1957</u>		REGISTRAR'S SIGNATURE <u>Cara Tachup</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Y. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09129

9134

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 7 yrs. 2 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W.. Last Langford		4. DATE OF DEATH Month September Day 20 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/14/07
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 19 Hours 57 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Railroad		10b. KIND OF BUSINESS OR INDUSTRY Farmer & Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. & Langford		14. MOTHER'S MAIDEN NAME Eleanor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 262-22-1890	
17. INFORMANT Hospital Records		Address Crownsville, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 561.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Paralytic Ileus (c) Incarcerated right Inguinal Hernia		INTERVAL BETWEEN ONSET AND DEATH Known to us since 11/22/49	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 22 , 19 49 , to Sept. 20 , 19 57 , that I last saw the deceased alive on Sept. 20 , 19 57 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		DATE SIGNED 9/23/57	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 9/25/57	
22c. NAME OF CEMETERY OR CREMATORY Harwoodville		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks		24a. REC'D BY REGISTRAR 9/25/57	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Dr. M. J. Jones	

SEP 27 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9105

CERTIFICATE OF DEATH

Reg. Dist. No.

09130

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>418 Severn Ave</i>		d. STREET ADDRESS <i>1418 Severn Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Harvey</i> Middle <i>Mason</i> Last <i>Mason</i>		4. DATE OF DEATH Month <i>9</i> - Day <i>9</i> - Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 27 - 1877</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>9</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boat Bld.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boat Builder</i>	
11. BIRTHPLACE (State or foreign country) <i>Deale Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Edward F. Mason</i>		14. MOTHER'S MAIDEN NAME <i>Anna Dougherty</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>William H. Mason</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cancer of prostate</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3 - 1957</i> to <i>9 - 9 - 1957</i> that I last saw the deceased alive on <i>9 - 3 - 1957</i> , and that death occurred at <i>9 - 9 - 1957</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		ADDRESS (Street, city or town, state) <i>63 College Ave</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>		DATE SIGNED <i>9-11-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-12-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St James</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Doyle Sons</i>		24a. REC'D BY REGISTRAR <i>9/11/57</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

SEP 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09131

9106

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 A General</u>		d. STREET ADDRESS <u>1009 Monroe St</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie K. Medford</u>		4. DATE OF DEATH <u>9 23 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>AA Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wilson Wells</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Brashears</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Harry J. Medford</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/23</u> , 1957, to <u>9/23</u> , 1957, that I last saw the deceased alive on <u>9/23</u> , 1957, and that death occurred at <u>10:00</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hildebrand</u>		ADDRESS (Street, city or town, state) <u>68 Franklin St. Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>		DATE SIGNED <u>9/23/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>9/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BULLDOZER 18

DATE OF DEATH

DECEASED

PLACE OF DEATH

AGE
SEX
RACE

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

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BUREAU V. 3

SEP 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09132

9135

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Germany</u> b. COUNTY <u>Bavaria</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>2 da 10 hr 35 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KAREN ADDIE ELIZABETH MILES</u>				4. DATE OF DEATH Month Day Year <u>September 19 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 September 1957</u>	9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>10</u>	IF UNDER 24 HRS. Days <u>55</u>	Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cecil Byron Miles</u>				14. MOTHER'S MAIDEN NAME <u>Margarete Schober</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Father, 1731 B Forrest Avenue, Fort Meade, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Focal atelectasis of both lungs</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Possibly Hyaline membrane disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 da 10 hr 55 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>16 Sept</u> , 19 <u>57</u> , to <u>19 Sept</u> , 19 <u>57</u> that I last saw the deceased alive on <u>19 Sept</u> , 19 <u>57</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAH, Ft. G. G. Meade, Md.</u> <u>19 Sept 1957</u>							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>USAH, Ft. G. G. Meade, Md.</u> <u>19 Sept 1957</u>					
PHYSICIAN'S NAME (Type) <u>THOMAS A. COOK, JR., MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 23, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc. 1217 St. Paul St.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>19 Sep 57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>Wilbur H. Downs, Jr. Capt. MSC</u>	

2050325XV1

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9136

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sylvan Shores, Riva</u> c. LENGTH OF STAY IN 1b <u>5 minutes</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u> <u>X2</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Donald Andrew Morris</u> First Middle Last			4. DATE OF DEATH <u>September 15th. 1957</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/49</u>		9. AGE (In years last birthday) <u>8</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending school</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prince George County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Robert C. Morris</u>		
14. MOTHER'S MAIDEN NAME <u>Eizabeth Pyles</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mr. and Mrs. R.C. Morris, (parents)</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Jumped in the river and failed to come back to the surface.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped in the river and failed to come back to the surface.</u>		
20c. TIME OF INJURY Month, Day, Year <u>3.45</u> <u>9/15/57</u> 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>South River</u>	
20f. (City or town) <u>Riva, A.A. Md.</u>		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/15/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	
22d. LOCATION (City, town, or county) <u>Hyattsville Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>			24a. REC'D BY REGISTRAR <u>SEP 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>L. J. Sealy</u>		

RECEIVED

SEP 19 1957

BUREAU V. 8

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Shady Side</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Irane</i> Middle <i>Nick</i> Last		4. DATE OF DEATH Month <i>Sept.</i> Day <i>11th</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 18, 1895</i>
9. AGE (In years last birthday) <i>62</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>W. JAMES Gross</i>		14. MOTHER'S MAIDEN NAME <i>Susan Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Marion Nick</i>		Address <i>Shady Side, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Hypertensive Cardiovascular Heart Disease</i> DUE TO (c) <i>Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Harry R. Jones</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Sept. 14/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Matthews</i>
22d. LOCATION (City, town, or county) (State) <i>Shady Side, Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 17 '57</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPT. OF HEALTH - DIVISION OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. 8

SEP 17 1957

RECEIVED

9107

CERTIFICATE OF DEATH

Item 9. Film G2212 12/3/57 for

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CC</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Epping Forest</u> X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A. C. General</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Nickerson</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Confectioner, Pet. Confectionier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Millington Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John R. Nickerson</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Campbell Simpson</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CORONARY DISEASE</u> DUE TO (c) <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>24 HOURS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>57</u> , to <u>9/13</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>9/13</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward Sheek</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave Annapolis Md</u>	
DATE SIGNED <u>9/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cell Hallows Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Danstonville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>9/17/57</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>J. T. French</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

SEP 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9138

CERTIFICATE OF DEATH

09136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold, x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Shore Acre Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Noonan</u>		4. DATE OF DEATH Month Day Year <u>9 22 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1886</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Lowell Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Noonan</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>wife - Mrs. Noonan</u>		Address <u>Arnold, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Congestive Heart Failure</u> (d) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-21-57</u> , 19 <u>57</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md.</u> DATE SIGNED <u>9-22-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		<u>Severna Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-24-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Laurens</u>	
24a. REC'D BY REGISTRAR <u>9/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>V. Ormick</u>	

BUREAU A. S.

SEP 25 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be kept for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Item 18 Film 221 10-11-57 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9139

09137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>Same</u> COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Arnold</u>		c. LENGTH OF STAY IN 1b <u>5 y.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>600 Shoreside Shore Acres Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hilda Jean Noonan</u>				4. DATE OF DEATH September 24th, 19 57			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? 1-16-1885</u>		9. AGE <u>72 1/2</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Jean Astell</u>				14. MOTHER'S MAIDEN NAME <u>? Sadie G Lyons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr and Mrs. Elmer Smith (Neighbors)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide (Cause is pending) caused by a mixture of drugs</u> <u>970.9</u> DUE TO <u>in the blood, the identity could not be determined.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 25th. 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Sept 28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sins Annapolis Md</u>				24c. REC'D BY REGISTRAR DATE <u>9/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED
OCT 2 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09138

9140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>				c. LENGTH OF STAY IN 1b <u>46 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 Glenvale Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Stevenson</u> Last <u>Oliver</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/76</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Albany Co. N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>							
13. FATHER'S NAME <u>Wm. Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Werner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Austin Oliver - same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Cervix</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9/13/57</u> to <u>9/13</u> , 19 <u>57</u> that I last saw the deceased alive on <u>9/13/57</u> , 19 <u>57</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Ball</u>				ADDRESS (Street, city or town, state) <u>Linthicum</u>			
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball</u>				DATE SIGNED <u>9/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 16/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>9/17/57</u>	

CERTIFICATE OF DEATH

WATLAND STATE DEPARTMENT OF HEALTH - BATHING 15

BUREAU V. S.

SEP 17 1957

RECEIVED

TO BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0913978

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANN ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE Md. Ty 13x0.2	
c. LENGTH OF STAY IN 1b 12 DAYS		d. STREET ADDRESS BOX 131A	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle PAGE Last PAGE		4. DATE OF DEATH Month SEPTEMBER Day 21 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 3, 1980
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME THOMAS PAGE		14. MOTHER'S MAIDEN NAME SAKAH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO RECORD	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PYELONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR D's 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-10-1957 to 9-21-1957 , that I last saw the deceased alive on 9-21-1957 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CROWNSVILLE STATE HOSP DATE SIGNED 9/21/57			
ACTUAL SIGNATURE John J. McGee M.D.		PHYSICIAN'S NAME (Type) JOHN J. MCGEE	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/25/1957	
22c. NAME OF CEMETERY OR CREMATORY MCLAUGHLIN		22d. LOCATION (City, town, or county) (State) ELKRIDGE Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter R. Williams ADDRESS 322 H. St.		24a. REC'D BY REGISTRAR DATE 9/24/57	
24b. REGISTRAR'S SIGNATURE K. M. Joyce			

SEP 25 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

25

9142

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A-A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PARK</u>				c. LENGTH OF STAY IN TB <u>37 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 9th AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>PARKER</u> Last <u>PARKER</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 3, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MISSISSIPPI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U-S.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>ANTOINETTE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS. AGNES BARANOWSKI SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 15, 1957</u> to <u>Sept 29, 1957</u> , that I last saw the deceased alive on <u>Sept 28, 1957</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Rubin</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>SAMUEL RUBIN MD</u>				<u>203 PATAPSCO AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE Hwy AA Co, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Foxe</u> ADDRESS <u>4001 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR DATE <u>9/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Hulse</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 1 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09142 28

9143 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1yr. 9mo. 18da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover 16 x 1.2	
4. DATE OF DEATH First Middle Last Charles Henry Ponger		4. DATE OF DEATH Month Day Year 9-8- 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 88? yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME * * * * *		14. MOTHER'S MAIDEN NAME * * * * *	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility and Malnutrition			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 19 57 to 9-8- 19 57 , that I last saw the deceased alive on 9-8- 19 57 , and that death occurred at 12:40p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9-9-57			
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Lionel McHenry Mapp, M. D.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-14-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Methu. Cem		22d. LOCATION (City, town, or county) (State) Lanham P. Sec. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons		ADDRESS 467 N. St. Md.	
24a. REC'D BY REGISTRAR SEP 16 1957		24b. REGISTRAR'S SIGNATURE M. J. Jones	

CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Lot of Baltimore

Household of Baltimore

Family of Baltimore

Sex of Baltimore

Age of Baltimore

Color of Baltimore

Religion of Baltimore

Marital Status of Baltimore

Occupation of Baltimore

Education of Baltimore

Place of Birth of Baltimore

Date of Birth of Baltimore

Time of Death of Baltimore

Place of Death of Baltimore

Cause of Death of Baltimore

Manner of Death of Baltimore

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RECEIVED
SEP 16 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09143

9108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN b 3hr. 20min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS 10		d. STREET ADDRESS 95 Sellers Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle PORTER Last PORTER		4. DATE OF DEATH Month September Day 14 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 September 1957
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jon Marshall PORTER		14. MOTHER'S MAIDEN NAME Julia May HOWARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND		Address U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity and Immaturity 776 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3hrs. 20 M	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 14 September, 1957 , to 14 September, 1957 , that I last saw the deceased alive on 14 September 1957 , and that death occurred at 4 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE John J. Egan Jr. ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL DATE SIGNED 14 September 57 PHYSICIAN'S NAME (Type) J. T. EGAN, Jr., CDR MC USN ANNAPOLIS, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-16-57	
22c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Tipton + Mrs. Annapolis, Md.		24a. REC'D BY REGISTRAR 9/17/57	
24b. REGISTRAR'S SIGNATURE O. Daniel			

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Mo.</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>F.A. GENERAL Hospt.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>25 FRANKLIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>B.</u> Last <u>RECORD</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>	11. BIRTHPLACE (State or foreign country) <u>MAINE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Willis RECORD</u>	
14. MOTHER'S MAIDEN NAME <u>LORINDA CAMPBELL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>YES</u> <u>W.W.I.</u>	
16. SOCIAL SECURITY NO. <u>W.W.I.</u>		17. INFORMANT <u>Sahlie M. RECORD</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>975x</u> DUE TO <u>drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Asphyxiation</u> DUE TO (c) <u>Asphyxiation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Asphyxiation</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a. m.</u> <u>p. m.</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-1-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis NATIONAL</u>		22d. LOCATION (City, town or county) (State) <u>Annapolis Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm M. G. L. + Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>9/30/57</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 2 1957

RECEIVED

9110

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MELVIN RD.</u>		d. STREET ADDRESS <u>MELVIN RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>O</u> Last <u>REDUE JR.</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN HENRY REDUE</u>	
14. MOTHER'S MAIDEN NAME <u>DEBORAH JONES</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>HENRY O. REDUE JR.</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cerebrovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 9/105</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__	20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1953</u> , 19__, to <u>9/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/27/57</u> , 19__, and that death occurred at <u>6</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>E. L. Linhardt</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUNDON PARK</u>	22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>9/30/57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. PLACE OF DEATH</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>	
<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>	
<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>	
<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>	
<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>	
<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>	
<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
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<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>	
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<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>	
<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>	
<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>	
<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>	
<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>	
<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

OCT 2 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sillery Bay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Nebraska</u> b. COUNTY <u>Lincoln</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>64X-3</u> d. STREET ADDRESS <u>721 South 42nd. Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Spencer Grady Richardson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3rd.</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/45</u>
9. AGE (In years last birthday) <u>12</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending school</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pasadena, California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Colonel John B. Richardson Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Jeanne Farley Spencer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Colonel John B. Richardson (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell overboard from sailboat</u>	
20c. TIME OF INJURY Month, Day, Year <u>12</u> <u>25</u> <u>9 3 57</u> Hour: <u> </u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Water</u>	20f. (City or town) (County) (State) <u>Anne Arundel Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. Fisher</u>		9-4-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/6/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FORENSIC DIRECTOR'S SIGNATURE <u>Wm. J. Hickner</u>		24a. REC'D BY REGISTRAR DATE <u>9/6/57</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Deady</u>			

RECEIVED

SEP 9 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9145

CERTIFICATE OF DEATH

Reg. Dist. No.

09147 28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				d. STREET ADDRESS <u>508 Oxford Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Scott</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown to us</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u>			
16. SOCIAL SECURITY NO. <u>-----</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Suppurative Pyelonephritis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Healed Myocardial Infarct</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-----</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	
20f. (City or town) <u>-----</u>				20g. (County) <u>-----</u>		20h. (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>Sept. 13th, 19 57</u> , to <u>September 15, 19 57</u> , that I last saw the deceased alive on <u>Sept. 15th, 19 57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict, M. D.</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>			
DATE SIGNED <u> </u>				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>				PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 19, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis A. Hensley</u>				ADDRESS <u>578 W. Bidwell St.</u>		24a. REC'D BY REGISTRAR DATE <u>9/18/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. M. Jager</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		AGE	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		PLACE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
SIGNATURE OF HEALTH DEPARTMENT		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE CITY CLERK	

BUREAU V. S.

SEP 19 1957

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9111

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>S</u> Last <u>Sharps</u>				4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-1910</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Sollars</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Lee Staters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-16-1948</u>		17. INFORMANT <u>William Sharps</u> Address <u>Anna, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mammary Carcinoma to chest</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>lymph nodes, liver and spleen</u> DUE TO (c) <u>Carcinoma of stomach</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/14/57</u> , 19 <u>57</u> , to <u>9/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/14/57</u> , 19 <u>57</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Rich</u>				ADDRESS (Street, city or town, state) <u>170</u> DATE SIGNED <u>9/17/57</u>			
PHYSICIAN'S NAME (Type) <u>William Seese, D. Anna, Md.</u>				M.D. <u>R. L. RICH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		22d. LOCATION (City, town, or county) (State) <u>Bristol, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Seese, D. Anna, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>9/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

BUREAU V. S.

SEP 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09149

9112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOHIS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>1000 JACKSON ST.</u>					
3. NAME OF DECEASED (Type or print) <u>ELIZABETH L. SLIDER</u>		4. DATE OF DEATH <u>9</u> Month <u>25</u> Day <u>1957</u> Year					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1915</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN PENKO</u>		14. MOTHER'S MAIDEN NAME <u>ANNA ONDER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ALONZO B. SLIDER</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma.</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Zaenker's carcinoma</u> DUE TO (c) <u>3 years.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-12</u> , 19 <u>57</u> , to <u>9-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-25</u> , 19 <u>57</u> , and that death occurred at <u>11:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peelen</u> M.D.		ADDRESS (Street, city or town, state) <u>Franklin St.</u>		DATE SIGNED <u>9-26-57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEPAR CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Giga + Sons</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>9/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Sept 28, 1957</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF DECEASED <i>John Doe</i>	
10. SIGNATURE OF WITNESS <i>John Doe</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. S.

SEP 30 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09150 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>7yrs., 6mths.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Snowden</u> Last <u>Snowden</u>		4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Snowden</u>		14. MOTHER'S MAIDEN NAME <u>India</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus due to fracture of Jaw</u> <u>983X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis. Emaciation.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck in jaw</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/17/57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Crownsville Anne Arundel Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Paul F. Guerin</u>		DATE SIGNED <u>9/26/57</u>	
EXAMINER'S NAME (Type) <u>Paul F. Guerin, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>SEP 30 1957</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Joyce</u>	

NEW YORK
STATE

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is mostly blank with some faint markings.

Handwritten signature

BUREAU V. S.

SEP 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09151

9147

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>11 yrs, 8 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital, Md.</u>		d. STREET ADDRESS <u>1315 East Biddle Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Stanley</u> Last <u>Stanley</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Caleb Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Annie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>-----</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>Known to us since 1/25/46</u> (c) <u>-----</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>023x Syphilis. Mental Deficiency without Psychosis.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>about 10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>January 25, 1946</u> , to <u>Sept. 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 30</u> , 19 <u>57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. Benedict</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		DATE SIGNED <u>9/30/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>A. D. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders</u>		ADDRESS <u>217 E. Preston St</u>	
24a. REC'D BY REGISTRAR <u>10/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. M. Jones</u>	

BUREAU V. S.

1957 3 OCT

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 21

9113

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RENEE Middle RUTH Last STARBECKER				4. DATE OF DEATH Month SEPTEMBER Day 9 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1957	
9. AGE (In years last birthday) 0 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Starbecker				14. MOTHER'S MAIDEN NAME Mavis Kennedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 759.3		17. INFORMANT Mrs Mavis Starbecker- Mother- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Multifocal Congenital Defects - including cleft lip. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cleft Palate, congenital malformation etc. (c) congenital heart etc.						INTERVAL BETWEEN ONSET AND DEATH 4-5 days Present at birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 763.0						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Aug 19 57 , to 9 Sept 19 57 , that I last saw the deceased alive on 8 Sept 19 57 , and that death occurred at 4:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 95 Calverton St. Annapolis Md DATE SIGNED 9 Sept 57							
ACTUAL SIGNATURE Philip Briscoe				M.D. Philip Briscoe MD			
PHYSICIAN'S NAME (Type) Philip Briscoe MD				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11, 57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cem.		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR SEP 13 1957			
24b. REGISTRAR'S SIGNATURE Mr. J. French							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 13 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09153

Reg. Dist. No.

9148

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Arnold Pasadena c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Same d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 65 Johnson Rd. Bar Harbor		d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) Walter William Stein		4. DATE OF DEATH Month September Day 23rd Year 19 57	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/85
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Germany, Europe.	
11. BIRTHPLACE (State or foreign country) Germany, Europe.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Oscar Stein		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-0471	
17. INFORMANT Mrs. Anna Stein (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED September 24th, 1957.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 25-57	22c. NAME OF CEMETERY OR CREMATORY Not known	22d. LOCATION (City, town, or county) (State) Brooklyn G G Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Ronald G. Fink		24. REGISTRAR'S SIGNATURE Louis J. DeAlba	

FOR STATE
HEALTH DEPT.

RECEIVED
SEP 26 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09154

CERTIFICATE OF DEATH

Reg. Dist. No.

9:49

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle W. Last Stewart		4. DATE OF DEATH Month 9 Day 9 Year 19 57					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1916	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson J. Stewart				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Hospital Records Address Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio-respiratory arrest 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Status Epilepticus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Paresis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-9- , 19-57 , to 9-9- , 19-57 , that I last saw the deceased alive on 9-9- , 19-57 , and that death occurred at 9:30a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 9-9-57							
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville, Maryland 9-9-57					
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11 1957		22c. NAME OF CEMETERY OR CREMATORY Union Chapel		22d. LOCATION (City, town, or county) (State) Davidsonville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty ADDRESS Galeville, Md				24a. REC'D BY REGISTRAR 9/13/57		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. S.

SEP 16 1957

RECEIVED

9114 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>X2</u> <u>Annapolis</u> RFD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. STREET ADDRESS <u>3 Kirkley Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS H. STINCHCOMB III</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 30 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1957</u>		9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas H. Stinchcomb Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Hilda E. Gosheff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT Address <u>Mr. Thomas H. Stinchcomb Jr Father same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>763.5 Pneumonia</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Pneumonia</u> DUE TO (c) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/29</u> , 19 <u>57</u> , to <u>9/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip Briscoe</u>		M.D. <u>95 Capital ST</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Maryland</u>		DATE SIGNED <u>10/1/57</u>	
PHYSICIAN'S NAME (Type) <u>Philip Briscoe MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>0013 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9150

CERTIFICATE OF DEATH

09156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 09132	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle W. Last Tilghman		4. DATE OF DEATH Month Sept. Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown (deceased)		14. MOTHER'S MAIDEN NAME Unknown (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 214-07-9501	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostate Bronchopneumonia, Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive and Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcer of Buttocks, Arterial Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from Sept. 29 , 19 56 , to Sept. 15 , 19 57 , that I last saw the deceased alive on Sept. 15 , 19 57 , and that death occurred at 9:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED ACTUAL SIGNATURE L. Benedict, M. D. PHYSICIAN'S NAME (Type) Crownsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/57	
22c. NAME OF CEMETERY OR CREMATORY Waucho Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. M. H. Clair		24a. REC'D BY REGISTRAR DATE 18 1957	
ADDRESS N. 317 High		24b. REGISTRAR'S SIGNATURE H. M. H. Clair	

BUREAU V. S.

SEP 18 1957

RECEIVED

9151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>None</u> <u>Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A A Co</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>11</u> yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>423 Ritchie Hgy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Taylor</u> Middle <u>C Walston</u> Last <u></u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4 1891</u>		
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leading Man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U S Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>L uther Walston</u>				14. MOTHER'S MAIDEN NAME <u>Trisane y Blake</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>705-05-9479</u>		17. INFORMANT <u>Freida W Walston 423 Ritiche Hgy Glen Burnie</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism And/ or Myocardial Rupture</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Postero-lateral Myocardial Infarction</u> DUE TO (c) <u>13 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/25/57</u> 19 <u>57</u> to <u>9/8/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/8/57</u> 19 <u>57</u> , and that death occurred at <u>5:30</u> A. M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Leonard H. Flax</u> M.D.			ADDRESS (Street, city or town, state) <u>113 7th Ave Brooklyn Park</u>					
PHYSICIAN'S NAME (Type) <u>Leonard H. Flax, M.D.</u>			DATE SIGNED <u>9/9/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Rd Balto Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson</u>				ADDRESS <u>2359 Wash Blvd Balto 30 Md</u>		24a. RECEIVED BY REGISTRAR DATE <u>SEP 11 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>L. J. Delley</u>				

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 11 1957

RECEIVED

9115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.P.C.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>GALESVILLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN'L</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Weston</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 6 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Galesville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Weston</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Diggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mrs. Elizabeth Weston</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malig. cerebral tumor</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>193x</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>45</u> , to <u>9/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson, Jr.</u>		ADDRESS (Street, city or town, state) <u>37 Calver St</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>		DATE SIGNED <u>9/2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	22d. LOCATION (City, town, or county) (State) <u>Galesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O. Harduty</u>		ADDRESS <u>Galesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>9/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU

SEP 13 1957

RECEIVED

8000

TO BE COMPLETED BY THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City

3. NAME OF DECEASED (Type or print)
First Middle Last William E. White

4. DATE OF DEATH September 23 19 57

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH Unknown 9. AGE (In years last birthday) 65 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 11. BIRTHPLACE (State or foreign country) Unknown 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unknown to us 14. MOTHER'S MAIDEN NAME Unknown to us

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes ☐ Unknown ☐ 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital Records Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized and Cerebral Arteriosclerosis
DUE TO
(c) CNS Syphilis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 21, 19 56, to Sept. 23, 19 57, that I last saw the deceased alive on Sept. 23, 19 57, and that death occurred at 6:20 a. m., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE M.D. Crownsville State Hospital, Md. 9/23/57
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. Crownsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Sept 26/57 22c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM. BALTO. Md. 22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1129 N. CAROLINE ST. DATE SEP 25 1957 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE X. M. Joyce

MD STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9152

CERTIFICATE OF DEATH

09159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 1 yr. 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1217 N. Dallas Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William E. White		4. DATE OF DEATH Month Day Year September 23 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY -----	
12. BIRTHPLACE (State or foreign country) Unknown		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME Unknown to us		15. MOTHER'S MAIDEN NAME Unknown to us	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> Unknown <input type="checkbox"/>		17. SOCIAL SECURITY NO. -----	
18. INFORMANT Hospital Records		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized and Cerebral Arteriosclerosis DUE TO (c) CNS Syphilis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 23. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 26. (City or town) (County) (State)			
27. I certify that I attended the deceased from Sept. 21, 19 56, to Sept. 23, 19 57, that I last saw the deceased alive on Sept. 23, 19 57, and that death occurred at 6:20 a. m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. Crownsville State Hospital, Md. 9/23/57 PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. Crownsville, Md.			
28. BURIAL, CREMATION, REMOVAL (Specify) Burial		29. DATE THEREOF Sept 26/57	
30. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM. BALTO. Md.		31. LOCATION (City, town, or county) (State)	
32. FUNERAL DIRECTOR'S SIGNATURE Milton E. Edickson		33. ADDRESS 1129 N. CAROLINE ST.	
34. DATE SEP 25 1957		35. REGISTRAR'S SIGNATURE X. M. Joyce	

BUREAU V. S.

SEP 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

9116

10253

21

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 10 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Best Gate Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Best Gate Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAM WILLIS		4. DATE OF DEATH Month Day Year September 25 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 50 yrs.
9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		DATE SIGNED 9/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-22-57	
22c. NAME OF CEMETERY OR CREMATORY V. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE 10/23/57	
24b. REGISTRAR'S SIGNATURE Wm. J. French			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 24 1957

BUREAU OF

Paul W. Jones